

Health and Social Care Committee

Oral evidence: Impact of a no deal Brexit on health and social care, HC 1583

Tuesday 23 October 2018

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[Watch the meeting](#)

Members present: Dr Sarah Wollaston (Chair); Luciana Berger; Mr Ben Bradshaw; Rosie Cooper; Dr Lisa Cameron; Johnny Mercer; Andrew Selous; Martin Vickers; Dr Paul Williams.

Questions 1 - 150

Witnesses

[I](#): Saffron Cordery, Deputy Chief Executive, NHS Providers; Professor Tamara Hervey, Jean Monnet Professor of European Union Law, University of Sheffield; Mike Thompson, Chief Executive, Association of the British Pharmaceutical Industry; Martin Sawyer, Executive Director, Healthcare Distribution Association; and Dr Mark Lloyd Davies, Senior Director, Medical Devices and Consumer Medical Technologies, Europe, Middle East and Africa, Johnson & Johnson.

[II](#): Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care; and Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care.

Written evidence from witnesses:

- [NHS Providers](#)
- [Association of the British Pharmaceutical Industry](#)
- [Healthcare Distribution Association](#)
- [Johnson & Johnson](#)

Examination of witnesses

Witnesses: Saffron Cordery, Professor Tamara Hervey, Mike Thompson, Martin Sawyer and Dr Mark Lloyd Davies.

Q1 **Chair:** Good afternoon and welcome to the Health and Social Care Committee's session this afternoon looking at the implications of a possible no-deal Brexit on health and social care. For those following from outside the room, may I ask you to introduce yourselves, starting with Professor Hervey?

Professor Hervey: I am Professor Tamara Hervey, Jean Monnet Professor of European Union Law at the University of Sheffield. I am also acting as a specialist adviser to this Committee.

Saffron Cordery: I am Saffron Cordery, deputy chief executive of NHS Providers. We are the membership body for all NHS trusts, covering acute hospitals, mental health trusts, community services and ambulances. We have 100% of trusts in membership.

Dr Lloyd Davies: I am Dr Mark Lloyd Davies. I work for Johnson & Johnson, covering medical devices for Europe, the middle east and Africa.

Mike Thompson: I am Mike Thompson, chief executive of the Association of the British Pharmaceutical Industry. We represent members who supply over 80% of the medicines to the NHS and all the global medicines—or almost all of them—that are in the pipeline to come through. With our sister agency, the BIA, we have made the submission to you.

Martin Sawyer: I am Martin Sawyer, executive director of the Healthcare Distribution Association, representing the larger wholesalers and distributors who distribute medicines, on average, twice a day to all hospitals, pharmacies and doctors, and get paid for it by the NHS.

Q2 **Chair:** Thank you very much. To start us off, will you, Professor Hervey, set out the legal context and background to what no deal means in practice?

Professor Hervey: Thank you, Sarah. I will do my best. Currently, health and social care in all the UK, including its devolved regional nations, is deeply integrated with the European Union. Pretty much everything to do with the way we organise health and social care has something to do with our membership of the European Union—the people who work in health and social care, the products we use, the structures we use, safety, research and all of those kinds of things.

All that integration is underpinned by European Union law—the way European Union law takes effect in our domestic legal system. If we leave the EU with a withdrawal agreement, it will be the legal basis of the way in which we leave the EU. If we leave the EU without that agreement, there will be no clear legal basis on which the UK leaves the EU.



That will mean that, from the point of view of the European Union, the UK will overnight become a third country external to the EU. UK nationals who are in EU countries, either visiting or residing there, will be treated as third-country nationals in EU law. Those people who have long-term residence status have some rights in EU law, including to basic healthcare, but everybody else has no rights in EU law. Let us say a pensioner retired to Spain a couple of years ago: they will have to rely on Spanish law to know what their entitlements are to healthcare. That becomes immediately much more confusing and difficult to understand. All the administrative systems that support interaction between the UK and the EU will cease to function because we do not have that legal underpinning for those administrative systems.

In terms of EU nationals in the UK or EU products coming into the UK, whether there is a deal or not, the European Union (Withdrawal) Act seeks to secure continuity. We know that the European Union (Withdrawal) Act will mean that products can be recognised that are coming into the UK, formally speaking. We do not know about the practicalities of how those products will reach the UK because anything that has to do with a cross-border element cannot be unilaterally legislated for in the UK. It has to be agreed with the EU, and, of course, no deal means no agreement.

Chair: Thank you. I am going to start this afternoon's session by looking at the implications for the pharmaceutical industry and medical devices. Ben is going to kick off the questioning.

Q3 Mr Bradshaw: Leading on from the scenario that Professor Hervey laid out of the UK becoming a third country, may I ask the four witnesses responsible for pharmaceuticals and medical devices and the provision of healthcare what in that scenario keeps you awake at night? Summarise your worst nightmares.

Mike Thompson: Perhaps I should kick off. What Professor Hervey has laid out explains why we need a deal, and we absolutely need an implementation period as well. Our main concern is to ensure that we can continue to deliver the medicines that patients need, both here and on the continent, through this period. That is the thing we have been working hardest to do.

Dr Lloyd Davies: Indeed, a deal is critical. Our biggest concern is that our company uses the British Standards Institution to CE mark—the old kitemark—the vast majority of our portfolio and a lot of the industry's portfolio. If we leave the EU without a deal, it will not be able to do that.

Martin Sawyer: As a third industry supplier, what keeps us awake at night is the uncertainty of no deal. On average, 50% of the medicines in most of our depots have been through the EU before they get to UK warehouses, and this whole integrated supply chain that we rely on was clearly set up after we joined the EU. It is only in the last 20 years that it has been put in place. It is very sophisticated—twice-a-day delivery,



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almost “just in time.” We normally have only two or three weeks’ stock in a wholesale warehouse, and it is very dependent on supplies coming in when they say they are going to come in. Any challenge to that without an arrangement that it makes a frictionless border will mean shocks to the supply chain. We are worried about shortages, patients not getting medicines and huge price rises for the NHS.

Q4 Mr Bradshaw: Saffron Cordery, as the person responsible for taking this stuff and delivering patient care with it, what is your worst nightmare?

Saffron Cordery: I have a number of worst nightmares actually. Healthcare is inherently a risky business and the uncertainty adds to that risk. Workforce supply is a huge issue, and we know it is already pressured out there in the NHS.

The timing and the timescales are critical. There has not been sufficient time for national-level planning, frankly, although it is speeding up now, and, coinciding with other pressures across the NHS, we are approaching winter, which we know is a hugely pressurised time for trusts on the frontline.

We also know that trusts are doing their damndest to meet their efficiency targets. They are going to have to take their senior time away from that and focus on planning for a no-deal Brexit. That does not put them in the best position.

Colleagues here have talked about supply-chain management, and that is fundamental. Things such as getting food into trusts is an issue, so we need to think about all those elements. It is not just about medical devices or pharmacy: it is about those broader issues as well. When someone is an in-patient, they are in the care of a hospital or a mental health trust and they need to be fed and watered.

Q5 Mr Bradshaw: Will the three gentlemen witnesses give me some examples that would be meaningful to people or patients who rely on medicines or medical equipment of things that might run dry—that there might be a shortage of—about which we should be really worried?

Mike Thompson: If we look at the scale of this, 46 million packs of medicines per month leave the UK for the continent and 37 million packs come back the other way, so we have a scale factor here. Almost all the latest medicines that we are producing are biologics and require cold-chain storage. That means that they have to be kept at between 2° and 8° from when they are produced to when they get to a patient. There are no cold-chain facilities at the border ports. That is why we rely on real frictionless trade to be able to move medicines quickly. Those are the things that clearly will give us challenges in the event of challenges at the border.

Dr Lloyd Davies: From a medical devices perspective, the No. 1 priority is to continue that supply of medical devices to patients and clinicians. Stitches are an essential part of all medical practice and surgery. Our



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company, Johnson & Johnson, supplies 69% of all stitches in the NHS, and they are CE marked by the British Standards Institution. If they are not able to undertake that process, we do not have the authorisation to supply those stitches.

Q6 Mr Bradshaw: Is that domestically or anywhere?

Dr Lloyd Davies: That is within the entire European Union and also into the UK.

Martin Sawyer: There is nothing specific I want to say. You have read about the shortage of EpiPens and methadone in the past. Any shortage can always rise to the surface very quickly because of the just-in-time nature. I have a weekly list here of where medicines have not been delivered to our warehouses. It is 13 pages long, which is quite normal. We work with the Department of Health and Social Care to manage supply through the NHS where we can because we can find product around the UK. I suggest that the system would become very unbalanced very quickly if there was a shortage in any particular area.

Q7 Mr Bradshaw: I was on the radio this morning with Julia Hartley-Brewer, a well-known Brexiteer, who said she would rather like a no-deal Brexit because none of this is going to happen, it is all scaremongering, we import stuff from the United States and the continental Europeans want to sell us their stuff, so there is not really a problem. How do you respond to the claim that there is not a problem?

Saffron Cordery: We would all be abrogating our responsibility if we did not plan for every scenario, because it is absolutely critical. We might be saying there could be no problem, but, fundamentally, we have to plan for that problem, whatever happens. We know that the supply chain, the workforce and all the issues across the NHS, are so interdependent—

Q8 Mr Bradshaw: Why would that dry up in a no-deal Brexit scenario? Explain to me in practical terms why the stuff would not come in.

Mike Thompson: If you look at my industry, very simplistically we have an integrated European supply chain. We have a supply chain that manages the Americans and one that manages the rest of the world. Any medicine that is brought in needs to be brought in under the licence that we have, which is a European licence. To move outside of that requires a lot of work. At the moment, everything has to come in through that way.

If we suddenly find that we are not able to get our medicines through the borders, then we have real challenges. Therefore, we have to be doing work now to prepare for that eventuality to ensure that, should that happen, we have a way of getting the medicines to the patients.

Q9 Mr Bradshaw: Is it the same for devices?

Dr Lloyd Davies: It is similar. In the examples I was giving, there are solutions without consequences. The solution is that companies that use the BSI to certify would start transferring their files to notified bodies



within the European Union so that they can do the CE marking, but this has a multi-million pound price tag associated with it, and the other notified bodies ask different types of questions, which has a risk of delay in the product being authorised in time.

- Q10 Mr Bradshaw:** That takes me on nicely to contingency planning. When some of you were last here we heard that AstraZeneca had already invested £40 million on the continent. The evidence from your organisation, Mr Thompson, to the Committee lists a whole string of pharmaceutical companies: AstraZeneca, £40 million in Sweden; GlaxoSmithKline, £70 million in other EU countries; and Lilly have gone to Spain, and so on. Is it possible to put a figure on how much you have already had to spend in moving stuff to the continent because of contingency for a no-deal scenario?

Mike Thompson: I think we can assume that it runs into hundreds of millions of pounds across the industry.

Mr Bradshaw: Hundreds of millions of pounds.

Mike Thompson: I think we have tried not to put the focus on the money. We are trying to put the focus on the patients, because the biggest issue is around patients not getting their medicines. This is not a situation where if we managed to get 80% of the medicines there that is a good effort and it is okay. Every single patient is reliant on their medicine, so we have to do that for every patient. That is the challenge we are facing.

- Q11 Mr Bradshaw:** If we get the deal you described last time—your preferred option—which was regulatory alignment, close to the single market and a customs union, would that investment come back, would that work come back, or is that gone for good?

Mike Thompson: The jobs that have gone have gone for good, but these are relatively small numbers in the scale of things at this moment in time. It is encouraging that politicians of all parties have supported in the UK continued medicines co-operation as the outcome that everybody is looking for. It makes absolutely no sense—for instance, if we think about infectious disease control, where at the moment we have one pan-European database in which we put all our information and can support each other by picking up trends—for us to have two separate databases.

It is the same with pharmacovigilance. Europe relies on 30% of adverse events being picked up by British doctors.

We are all in this together, and that is recognised. The challenge has been that the EU has failed to give any signal about what co-operation they would like until some substantive issues have been resolved. Therefore, we are getting very close to something that could be very difficult indeed, and we do not know exactly what they would want. I



think there is absolute consistency among everybody that continued co-operation is what is in the best interests of patients and public health.

Q12 **Mr Bradshaw:** Where are we now on stockpiling?

Mike Thompson: The Secretary of State wrote to everyone asking them to build an extra six weeks' stock, which we have been doing. The Department has surveyed our members and I think is very pleased indeed with what we have been able to do. I think that is because a lot of people had started in advance of that request. I wrote to my members in December last year and asked them to start planning for no deal because our industry has the longest supply chains of any industry. We typically can take up to a year to establish a supply chain for a new medicine, so you need to remember that we are now less than six months away, potentially, from a hard Brexit.

If we had not done the work, it would now already be too late. Companies have done the work and we, I think, have had a very good response to it, but we have always said that stockpiling will in itself not be enough to protect British patients. We will need to consider other things as well.

Martin Sawyer: We have no sight of where the gaps are in that stockpiling. Pre-wholesalers in our membership are going to stockpile with Mike's members. We have no view on where the gaps are yet, and there is little time to build up new supply lines for those gaps, so it is not going to be the be-all and end-all, I am sure.

Saffron Cordery: A letter has gone out to the NHS, as providers of services, explicitly saying not to stockpile drugs. It is on the industry side that that is being managed and the NHS has been told not to stockpile drugs. Of course, if we do not have that oversight of what is happening nationally and then what the supply is going to be into local trusts and local pharmacies and so on, that is also a substantial concern. It is worth bearing in mind that there is a separation between what is happening nationally and locally.

Q13 **Mr Bradshaw:** What do you think about the six-week figure? Where has that come from?

Dr Lloyd Davies: On the medical device side, we stockpile to four weeks because we have been given the direction that the routes that we use—Zeebrugge to Hull and then air transportation into Doncaster airport and East Midlands—are sufficient in that they do not see bottlenecks appearing there. Four weeks has been the advice we have been given. We follow that.

Martin Sawyer: That has been governed by people being told to work—

Q14 **Mr Bradshaw:** Do you think that is enough? If we see some of the problems that have been predicted at Dover, is six weeks going to be enough?



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Martin Sawyer: I think the problem is at Calais. We need the infrastructure to come backwards and forwards because most medicines come in through Dover and Folkestone, and we do not know how France, or the EU, is going to treat the UK. If we are treated as a third country, the boats and lorries will be tied up in Calais; they will not come back because it is a closed-loop system, using—

Q15 **Mr Bradshaw:** Do you think we should be aiming for a stockpiling of longer than six weeks?

Martin Sawyer: We have not seen the basis on which that six weeks has been developed, so we cannot answer the question.

Q16 **Mr Bradshaw:** You have not seen the basis on which it has been developed. Mr Thompson, what do you think the basis is?

Mike Thompson: We have to rely on what Border Force advise Government is the requirement. A number of my members have stockpiled for more than six weeks because those are standard buffer amounts that they would have, but, as I said in my evidence to the ExEU Committee, I think that is a key assumption that we are making. However, I think we have always been clear that stockpiling will not be enough—

Q17 **Mr Bradshaw:** Explain that.

Mike Thompson: There are some other things that we need to do. For instance, take our latest medicine where we take a bit of DNA out of a patient, it goes to the continent, they modify it, and they bring it back and put it back into the patient. You cannot stockpile a person's DNA. We need to have some routes that may be fast-track routes, it could be air lifting, or it could be, in extremis, opening up other supply lines. For instance, we could decide that we would look to bring some products in from America, but we need to recognise that a product is currently signed off to a completely different licence by the FDA, so a lot of preparatory work would need to be done to ensure we were able to bring American products in.

It is the same for the generics industry. Some Indian suppliers currently do not supply the UK but have licences. Again, you could do some investigation to bring some extra stock in there.

This sector is, I think, more advanced than any other sector in planning, which is needed because of the long-term supply chains, but we will need to look at other things as well to guarantee that we do the best that we can.

Q18 **Chair:** Lots of colleagues want to come in, but may I press on a point of clarification before I bring them in? You, Mr Thompson, mentioned that hundreds of millions have been invested to date. Does that include planning for complex warehousing, including refrigerated warehousing and so forth, which you say is lacking? What does it cover so far, and



what do you anticipate is down the track in terms of total cost?

Mike Thompson: We know that there is not enough cold-chain warehousing in the UK today to cover the stockpiles we have been asked to build. There is a request in to Government to support the building of additional cold-chain supply. There are enough ambient warehouses, we believe, but not enough cold chain.

Chair: Unfortunately, there is a Division in the House, so we are going to have to suspend while Members go to vote. When we come back, it would be really helpful to have some idea about where the costs are, as you say, now and in future and including for devices, perhaps from you, Dr Lloyd Davies, if that is okay. We will suspend for a short period.

Sitting suspended for a Division in the House.

On resuming—

Chair: Although a few Members are yet to come back, we are quorate so we will start because I am very keen that we should have on record as much as we can from you this afternoon and I understand that several of you have to leave at 4 o'clock. Is that correct?

Dr Lloyd Davies: Four-thirty.

Q19 **Chair:** As we were leaving, I was asking Mike Thompson if he could set out in a little more detail the costs the industry faces as a whole and then I was hoping to come on to you, Dr Lloyd Davies, to hear about the situation for Johnson & Johnson. As you say, you mentioned that it was hundreds of millions already. What do you anticipate to be the total cost that we are already committed to, given the uncertainty we face?

Mike Thompson: It is difficult to put a total number on it because individual companies have had their own costs. Pfizer posted a cost of \$100 million in their latest quarterly accounts. I think people will start to see things being posted in companies' accounts. Obviously, there is the cost of stockpiling, which is a very significant cost.

Secondly, companies have had to build duplicate testing laboratories on the continent. That does not sound very much, but, as I always say to people when we do quality control, this is not somebody with a clipboard at the end of a line; this is building a laboratory. You take a medicine, you have to analyse it to make sure the active ingredient is exactly there in the quantity it is meant to be and the medicine is working in the way it should be. That is why patients can be reassured that, every time, a medicine is going to work.

GSK and AstraZeneca have allocated over £100 million just to build duplicate laboratories on the continent, which is why we have been asking the EU to take the same decision as the UK has taken. The UK have said we will take medicines that have been manufactured in, say, the continent. We will accept them being used for UK patients, as they



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are today, but in the event of no deal we will continue to allow that to happen.

The EU has not done that, and why that has not happened is obviously disconcerting to companies. Our request is that it should do that. That has made a huge difference to our ability to supply in the UK.

Q20 Chair: Thank you. I will come back to the point about qualified persons and some of the other complications around that in a minute, but, Dr Lloyd Davies, will you talk us through in more detail the situation for Johnson & Johnson?

Dr Lloyd Davies: Our focus has been on increasing warehouse space and hiring additional staff. We have increased our transportation capacity by 15%. The cost of that is a £1.1 million spend at the moment.

On the issue I mentioned about the British Standards Institution and whether we have to move to another European Union-based notified body, the trigger has not yet been pulled on that but will need to be pulled very soon. The costs will be between £40 million to £50 million.¹

If there were a no-deal scenario, between 2019 to 2025, assuming that at some point there would be regulatory divergence—I know the UK Government have said that they would accept the CE mark and accept European regulation to begin with—if there were to be a change in the rules within the European Union, and if the UK Government were not to track with that, we have assumed that in our model and we calculate that costs will increase to over £150 million by 2025.

Q21 Chair: Right—by 2025. When the Government spoke about contingency planning and things like warehousing and airfreight, they mentioned that the cost would be reimbursed by Government. Have you been given any kind of indication of how that would work and how it would filter down?

Dr Lloyd Davies: None at all.

Q22 Chair: How about you, Mr Thompson?

Mike Thompson: No. I believe it is still a conversation going on in Government. We would say there are smaller companies that are finding this very challenging indeed.

Q23 Chair: They could actually risk going under if it is not being reimbursed.

Mike Thompson: They just do not have a really effective cash flow when they are a small company, so these things are significant. I think it is in the best interests of the Government to provide support for smaller companies and to ensure that there is effective warehousing available.

Dr Lloyd Davies: Johnson & Johnson is different in this way, but 98% of the UK medical device industry are SMEs.

¹ "Note by witness: These costs are a conservative estimate."



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Q24 **Chair:** Thank you. There may be aspects that will not be reimbursed: for example, you supply direct to the consumer in many cases for your products, do you not?

Dr Lloyd Davies: On the consumer side of our business, yes.

Q25 **Chair:** Will there be cost implications directly for consumers?

Dr Lloyd Davies: On the consumer side of business, there will be supply-chain costs. There is not the same issue of the British Standards Institution, but there will also be approximately a 1% tariff increase if we fall under WTO rules, and that will be passed on to the consumer.

Chair: I am conscious that lots of members want to come in. I am keen to bring in Martin first, if I may.

Q26 **Martin Vickers:** Mr Thompson, in one of your last answers you have partly answered what I was going to ask about because earlier you referred to the EU not being prepared to go into some detail until they had had some substantive responses on other issues, which in effect you have now answered by saying that in actual fact they are not prepared to negotiate— they are not being particularly helpful and co-operative.

Mike Thompson: Everybody needs to put patients and public health first. There are some really serious issues that are going to impact patients across the whole of Europe. Guido Rasi, the well-respected head of the European Medicines Agency, has made it clear to politicians on the continent that he believes there will be medicine shortages on the continent. In that situation, it is really important that politicians do everything they can to ensure an effective supply of medicines. Therefore, our ask is that the EU do the same as the UK Government have done and that they do it as soon as possible.

Q27 **Martin Vickers:** You referred earlier, I think, to the fact that you sent a letter in December 2017 urging businesses to consider a no deal. Why did you leave it until December 2017—18 months after the referendum?

Mike Thompson: A number of companies have been planning since the referendum. There are always those companies, particularly smaller companies, that do not have the same resources as bigger companies. I wanted to make it absolutely clear to them that our advice as a trade association was that they now needed to put significant effort into ensuring that they were planning for no deal. Therefore, we wrote the letter to put that. We felt that at least 15 months before a potential no deal was enough time for almost all supply chains to be changed, but we believed that decisions had to be made then and not later.

Q28 **Martin Vickers:** You were also—I think it was Mr Thompson, but others may wish to come in on this—referring to the transition phase. What would be the minimum transition period that you would prefer?

Mike Thompson: If you ask anybody from business, they would like to have as long a transition as possible. We recognise that that is politically



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difficult and, therefore, I think what we are saying is that a transition period will make a huge difference to no deal.

Q29 Martin Vickers: You rightly point out that the Government have political difficulties in transition, but the reality is that the public at large, and even in a constituency like mine that voted 70% for Brexit, are not concerned about the fine detail of a transition agreement about moving pharmaceuticals and medicines around. They are interested in what the headline issues were at the time of the referendum.

In effect, you are saying that the EU 27 are holding back, and, quite understandably, you are urging them to co-operate and fall into line with what the British Government have had on offer. Much criticism is hurled at the Government for not being able to answer these questions, but it is fair to say that the fault is on the other side of the channel.

Mike Thompson: We are very grateful—and Jeremy Hunt and Greg Clark wrote a letter in the *Financial Times* as long ago as July last year making it clear—that the UK Government wanted continued co-operation on medicines as we exited the EU. That was a very clear statement. If you look at the Prime Minister's Mansion House speech, it has been laid out clearly there and followed up in the White Paper. I do not think the UK Government could have been clearer about what they were looking for.

If you look at all the stakeholders, whether it is in the research community or whether it is clinicians, everybody is saying this is what is in the best interests of patients and public health. There is a real uniformity of views—it is quite remarkable. My industry has a single view for everybody in the industry across the whole of Europe in terms of what we think is the best outcome.

I recognise that negotiations are difficult. We are now under six months away from, potentially, a hard Brexit and are running out of time. I shall give you an example. A company that is manufacturing medicines in the UK also has to plan the supply chains of all the ingredients that come into the UK. That single company has to revalidate over 15,000 supply chains for individual elements so that we can continue to supply those medicines to patients across the whole of the continent. People do not always understand the complexity that we are being faced with, and that is the challenge and why a transition period is really essential.

Chair: Saffron is keen to come in.

Saffron Cordery: I want to come in on the supply-chain issue. It is really important that we broaden this out because it is not just about supply chain when we look at things such as pharmaceuticals and medical devices. They are critically important, and I am not saying they are not, but the NHS is an immense industry in its own right. NHS trusts are complex beasts. The NHS employs a million people, it has an £87 billion



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budget and there are 227 NHS trusts delivering services up and down the country. We need to think of that industry as well.

One challenge we face is the separation between what we have in terms of medical devices, pharmaceutical distribution and that kind of thing and other contracts. Only now has the Department of Health and Social Care issued a methodology for the supply chain for all the other contracts that sit outside the big beasts, as it were. We need to look at the interdependence between these things. It is about the supply of goods for capital contracts, for transport, for back-office services, for IT—all those issues—alongside what we think of as strictly medical. It is what it takes to run an organisation. We need that interdependence and we need to look at what NHS providers need almost as an industry and then work out from there as well.

That is not to undermine the work that has gone on here—the big pillars of what is being delivered—but we need to look at NHS provision from the centre outwards and think: what do we need for NHS trusts to carry on doing their day job in the round, not contingency planning here, supply chain here and medical devices here? That has not happened yet.

Q30 **Chair:** You are saying a co-ordinated approach is needed to it.

Saffron Cordery: Yes.

Q31 **Andrew Selous:** May I go back to the stitches you were talking about, Dr Lloyd Davies? Forgive me if I have not understood this properly. I think you said Johnson & Johnson supply 60% of stitches used in this country. What proportion of those stitches are made here in the UK?

Dr Lloyd Davies: Very few of them. In fact, now almost zero are manufactured in the UK. They are manufactured in Mexico, but they have to receive a CE mark to be authorised to sell within the UK and within the European Union.

Q32 **Andrew Selous:** In the event of no deal, stitches would be imported into the UK from Mexico, and they currently meet British standards, so what would be the problem? Could we not just say that they already meet our standards, which were the European ones? I do not quite understand what the problem would be with carrying on importing them.

Dr Lloyd Davies: They would be imported into our European distribution centre based in Belgium, then transported across to the UK, so there would be the EU-UK border. The key thing is that if the body that allows them to be sold in the whole of the European Union and the UK—the British Standards Institution—cannot do its job by authorising by CE marking for the European Union, they will not receive that mark of authorisation and cannot be sold in the UK or, in fact, in the European Union. The body that has that power that the UK has said it will recognise will have that power taken away from it if it cannot CE mark from out of the UK.



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Q33 **Andrew Selous:** I understand that. Would it be logistically very challenging to have those stitches come directly into the UK and not go via Belgium?

Dr Lloyd Davies: It would be logistically possible, but we could not sell them without a CE mark.

Q34 **Andrew Selous:** Even though they would meet the British equivalent standard, it would still be a problem, would it?

Dr Lloyd Davies: Yes, because the British Standards Institution have not given any indication or done anything about CE marking, which is the current standard, if you like.

Q35 **Andrew Selous:** That is, I guess, one that you are sending back to us as legislators to say that would be an issue we would need to address.

Dr Lloyd Davies: Indeed.

Q36 **Andrew Selous:** May I move on to the issue of cold-chain storage? What proportion of the 37 million items of medicine that come into the UK require cold-chain storage?

Mike Thompson: We do not have a number in terms of absolutes.

Q37 **Andrew Selous:** Just a rough proportion; give us a ballpark figure.

Mike Thompson: I can tell you that half of the new medicines that were approved last year require cold-chain storage.

Q38 **Andrew Selous:** I am sorry—half of those that were approved last year?

Mike Thompson: Yes. This is very much at the leading edge of medicines that are being developed, which tend to be biologics and therefore require cold chain. Vaccines also normally need to be stored, so significant parts of our supply chain have cold-chain requirements.

Q39 **Andrew Selous:** Presumably cold-chain storage, and I have visited some of it in my own constituency so I am familiar with the concept, takes longer and is more expensive to build than a standard warehouse.

Mike Thompson: Correct, which is why we are saying to Government: you need to press the button now. Normally this would take longer than six months to build and get it signed off because it needs to be regulator-approved and authorised. I guess some of these things can be truncated, but we believe we are very much up against the deadline now.

Q40 **Andrew Selous:** What is the quickest time span, assuming you were given planning permission—

Mike Thompson: I am going to turn to Martin to comment on that.

Q41 **Andrew Selous:** How quickly could you put up a large cold-chain storage warehouse?

Martin Sawyer: I think you are talking more than a year.



Q42 **Andrew Selous:** More than a year.

Martin Sawyer: Yes, because, from my experience of pre-wholesalers' building capacity, they usually plan it at least two years ahead of time. As Mike says, they have to have regulatory approval from the MHRA and there are more regulations required with cold chain, as you might imagine, than ambient storage, which is above 8°. Ambient storage, for the stockpiling, is easier because we can use capacity that is not already being used for medicines from other sectors perhaps.

Q43 **Andrew Selous:** So there is a particular issue with the need for frictionless trade in medicines that require cold storage, is there not?

Martin Sawyer: Yes.

Q44 **Andrew Selous:** You are saying that it takes a year to build capacity.

Martin Sawyer: Indeed, because the vans have to have fridges, and being stuck on the side of a motorway, or whatever, might be a challenge.

Andrew Selous: They might run out of generating capacity and so on, yes, okay.

Q45 **Chair:** To clarify, do we have sufficient capacity at the moment?

Martin Sawyer: For current needs in the UK, yes.

Q46 **Chair:** But not to stockpile the extra amounts—

Martin Sawyer: That is the exercise being undertaken at the moment by the Department, and we have been working very closely with them to try to ascertain what the capacity for cold chain is and whether some more cold chain can be brought on from other sectors, such as the food industry, for example. That scanning exercise has been going on to look at capacity.

Q47 **Andrew Selous:** May I go back to Saffron Cordery on the food issue? I was a little surprised to hear you say that the supply of food to NHS patients might be a problem. I have heard from the major supermarkets that they are talking about possible price rises, and I guess there may be some delay, but I do not think anyone is thinking that food is not going to be available, are they?

Saffron Cordery: In the advice that has come out from the Department of Health and Social Care they have looked at national contracts for food, so it is not just us saying it. It is the fact that we need to look at supplies of foods into large catering supplies. Catering contracts come under the national provision, so they will be looked at nationally in the event of a no-deal Brexit.

There are also things such as supported nutritional supplies that are not quite medicines but are nutritional aids to patients and things like that.



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So, there are two categories, but they are being looked at in the scenario of a no-deal Brexit.

Q48 **Andrew Selous:** That is stockpiling dry goods, is it, or more cold-capacity storage?

Saffron Cordery: I do not know the detail, but the ongoing supply of food for large-scale catering, obviously, is an issue.

Q49 **Luciana Berger:** May I get a bit more clarity on some of the questions that have been asked, specifically about the cost of stockpiling and alternative options? A figure was put on the cost of stockpiling of around £2 billion. I wonder whether that was accurate. Is that cost wholly being borne by industry or have you had any support or indication of support from Government?

Mike Thompson: If you look at six weeks of medicines, the cash value to buy the six weeks is about £500 million, and then you have to look at the cost of working capital that would be tied up, which would be much smaller—£30 million to £50 million, something like that. I think the £30 million to £50 million will fall on everybody.

For smaller companies, cash is obviously a much bigger issue, so it is the smaller companies that we are most concerned about with their ability to do what we would like them to do in organising stockpiles.

Martin Sawyer: In answer to the second part, in Matt Hancock's letter of 23 August, I think, he said that the Government would look at options to cover the cost of storage.

Q50 **Luciana Berger:** Yes, but in terms of what has happened since that letter, that was two months ago.

Martin Sawyer: Yes, and the Government have continued to look at those options and have not made, as I understand it, any public decisions.

Q51 **Luciana Berger:** We have heard evidence about alternative options that need to be considered in addition to stockpiling, because stockpiling alone will not be enough for some pharmaceuticals. Have you had any indication from Government about what specific support they are going to extend to you, whether it is the air lifting you mentioned or any of the other options you might be considering?

Mike Thompson: We are at the phase where I would expect the Government now to have a good view about what stockpiling will do. I think we are in the phase now of working through what those other options are. For instance, 90% of medicines come in through Dover and Folkestone on roll-on/roll-off lorries. There is clearly a different way of supplying the UK, which is called lift-on/lift-off through different ports. At the moment, almost no companies have that as a secure supply chain, so I think we would need some help to try to establish that as an alternative way of bringing things in. That would need to be revalidated and worked through.



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We are looking at what capacity is available through airlines. Again, we do quite a lot of lifting of clinical trials. Clinical trials is another good example where we cannot store the medicines. Typically, we would deliver those through airlines anyway.

The work that is ongoing at the moment from our perspective is also to try to find out what capacity is available, recognising that in the event of a no deal probably lots of people are going to be trying to fly things through.

I think there comes a time when we have to think about fast-track lanes: what can we do for certain things that we want to prioritise to go through? All that needs to be worked through so that, if we get to the point where we unfortunately end up with no deal, those people who are on the frontline have some clear guidance about what to do so that we can continue to ensure that medicines get to patients.

Q52 **Luciana Berger:** As yet, you do not have that guidance.

Mike Thompson: I think that is the phase into which we are now moving.

Q53 **Dr Cameron:** I have a couple of follow-up points. In terms of stitches and catering supplies, we understand the short to medium-term implications you are dealing with, but, over the long term, could the UK consider manufacturing stitches?

Most patients in hospital would like local, good food. I wonder whether there is an opportunity in the long term to look at self-sufficiency and at using local producers a lot more for those supplies.

Dr Lloyd Davies: We are consistently doing strategic reviews of manufacturing location decisions: are we in the right locations to place manufacturing? There is the UK and the EMEA region, which are frequently reviewed as to where we place a manufacturing plant. We put it in different places.

In answer to your specific question about the UK, a lot will depend on what happens, the result of the UK withdrawing from the EU and what sort of agreement or regulatory alignment is in place.

Q54 **Dr Cameron:** Over the long term, if regulatory alignment is in place, how do you see that impacting on our ability to manufacture?

Dr Lloyd Davies: If there is regulatory alignment, or ideally mutual recognition of regulations, it becomes easier to invest in manufacturing.

Q55 **Dr Cameron:** What about local food for catering?

Saffron Cordery: It is helpful that you ask that question. To follow up on the answer I gave earlier, this is being looked at by the Department of Health and Social Care at a national level. It is exempted from what trusts should look at for their own supply chains. The centre has taken hold of this one and it says: "This category is being reviewed and



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managed centrally by DHSC. Instructions will be given to major producers of patient meals to put in place contingency arrangements to account for short supply of certain ingredients imported from the EU. Guidance will be provided to hospital caterers, procurers of patient food and catering services and PFI providers on actions to take into preparing to use substitute foodstuffs to maintain nutritional balance.”

It is a widespread issue—it will not just be about catering for hospitals. This will be any kind of mass catering, so schools and the armed forces. We will be looking across the piece.

There is often local procurement of hospital catering, but sometimes local procurement is from companies that are importing from the EU, so that is local companies rather than local foodstuffs. What we are talking about is something way down the line in sourcing all food from your local area to supply the catering for a hospital trust. We are talking about contingency arrangements over a period of time. We are not talking about the long-term supply, but I think that is important to remember.

Chair: We need to look at the big picture, but I am quite keen that we focus for the time being on pharmaceuticals and devices.

Q56 Mr Bradshaw: The Royal Pharmaceutical Society warned in, I think, *The Sunday Times* that there are already shortages and that they will get worse in the event of a no-deal or hard Brexit. Mr Sawyer, you were on the radio this morning talking about the need for Government to take emergency powers in that scenario. Will you explain why you think that is necessary?

Martin Sawyer: Yes. If there is no deal, as Saffron referred to earlier, we need to make use of, if you like, the NHS’s command and control mechanisms to allow for certainty of supply of the medicines that we do have in the country at that time. Remember that in a no-deal scenario the ports will be a challenge for some time, so we think that what medicines are in the UK should be managed more appropriately—for example, allowing pharmacists to substitute prescriptions, perhaps alternate prescriptions to medicines that they have available, and allowing pharmacists to share and use other pharmacies’ medicines, which they used to be able to do but cannot do at the moment by law. You could relax that law to allow a local community to share medicines around.

The other point I suggested this morning is to remove and stop all wholesale licences for a limited time. There are 2,500 of them out there. It allows for a lot of trading and for a lot of export of UK packs that we would want to keep in the country. Our members have 20 of those licences and we distribute 90% of the NHS medicines, so there are a lot of small businesses out there whose main business is not wholesaling and distribution. The Government and MHRA could control it to just those businesses whose main or only purpose is distribution. France has 35 wholesale licences, and that is what they do. We have 2,500 because it



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allows for a free market, which has produced very low prices for generics—I cannot deny that and the Government have saved £11 billion over 10 years—but no deal would be a catastrophic time for medicines supply. I am not pulling any punches. I think we have to think of emergency powers.

Q57 **Mr Bradshaw:** This could involve patients being put on different drugs from the ones they are used to without consultation with their GP.

Martin Sawyer: Correct.

Q58 **Mr Bradshaw:** Finally on the stockpiling, I want to nail this down with you, Mr Sawyer and Mr Thompson, and ask you directly: is the current advice from the Border Delivery Group to the industry that a six-week stockpile will be sufficient for NHS patients in the event of no deal?

Mike Thompson: That is the current advice.

Martin Sawyer: That is what we have been told.

Q59 **Dr Williams:** Patients listening to this evidence might be alarmed at some of the prospects for no deal, a potentially catastrophic time with emergency powers and patients put on different drugs from the ones they are prescribed. Should patients be stockpiling their own drugs?

Martin Sawyer: I would say no. We are here on behalf of patients. We are trying to sort this issue out and make sure politicians of all parties understand the concerns we have, because we are concerned. This is one of the last opportunities we might have to speak in this type of forum. We are very concerned as businesses. We cannot plan against uncertainty. Certainly, our businesses cannot invest as our margins are very small. We need politicians to understand that there could be consequences of a no deal, and those are the consequences. We are not suggesting that anybody needs to stockpile outside of the supply chain yet, but, come January, that might be a different picture and, as businesses in the supply chain, together with the Government and the NHS, we will have to communicate what needs to be done. We are, we believe, going to be in a difficult situation if there is not a deal by Christmas.

Dr Lloyd Davies: From our company's viewpoint, our first priority is making sure that our medical devices and technologies get to the patients and clinicians in as smooth a manner as is possible, but that is going to have associated logistical costs and complexities. That is what we are working on at the moment.

Mike Thompson: I recognise the points you raise. In my conversations with the media I ask them to be very thoughtful about how they report these issues, because the most vulnerable in society could be particularly alarmed by that. We need to be thoughtful about this.

I am trying to communicate that we are doing absolutely everything in our power. I work for an industry that I have seen do remarkable things to ensure that we get a medicine to a patient. We have been doing that



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for some time now, and, with the support of everybody, we are looking to ensure that we do that.

We also need to be honest with Government and Parliament and say that there are more things that need to be done in a no deal. I think we have reached the stage of recognising that stockpiling will not be enough and we need to put in the next phase of plans. Officials in the DH have done a very good job in working through methodically where we are so that they can accurately manage the situation, but some of the things we have talked about today would be above just one Department, which would be required, essentially, to ensure that Government put in place what was required to ensure a continued flow of medicines. We are very close to that point now.

Q60 **Chair:** Before I come to you, Saffron, may I bring Tamara Hervey in here? We have heard that regulatory alignment and mutual recognition are going to be important, but in the event of no deal how likely is it that we are going to see those in place if there is no deal and no transition?

Professor Hervey: In the event of no deal the UK can choose to align with the EU, but the EU has no obligation to choose to align with the UK. For a complex supply chain, that does not help, because you have both borders in play.

Q61 **Chair:** In other words, it is unrealistic to say that we will just open our borders and everything can come in, because that does not work for a complex supply chain.

Professor Hervey: Yes.

Q62 **Chair:** Thank you. Saffron, you wanted to come in.

Saffron Cordery: You were talking about stockpiling medicines and things, but that takes us to a slightly broader point around contingency planning and the length of time for which contingency planning should run.

NHS trusts have been encouraged—in fact, told—to use their emergency preparedness, resilience and response planning process, which is the ongoing contingency planning they would use for any emergency scenario. The methodology for that is good, but it is based on returning trusts to a “business as usual” scenario. We know that after a no-deal Brexit “business as usual” is an unknown. That is the bit we have to be fully alive to—that we are not necessarily returning to business as usual, so, yes, we need to do some contingency planning, but we also need to do some different scenario planning as well. We have been asking for a set of shared assumptions so that we can understand a little more about what might unfold post the six-week period following a no-deal Brexit. As one of my colleagues said, it is the period after that about which we need to think as well.

Q63 **Chair:** We are moving to a different system entirely.



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Saffron Cordery: Yes.

Chair: We have an awful lot to get through this afternoon. Andrew, do you have any further points to raise on contingency planning?

Andrew Selous: No.

Chair: We will move to Luciana and the issue around engagement.

Q64 **Luciana Berger:** Saffron, we saw an email exchange over the summer from your organisation with the chief executive of NHS England and the chief executive of NHS Improvement on behalf of your members, raising some concerns about a number of different things, but particularly about the lack of formal communication to trusts across our country on preparing for a no-deal Brexit. Can you share with us any progress since that letter two months ago?

Saffron Cordery: There has been progress since then. It is fair to say that it is the Department of Health and Social Care's responsibility to be communicating with the sector, but we know that the central bodies—NHS Improvement and NHS England—have a key role to play in facilitating that.

It was very slow over the summer. I think it is fair to say that it has now speeded up and there have been lots of communications. However, one issue we have is that the process is not yet fully formalised, there is not a regular flow of information, it is pretty piecemeal, and it goes to different places in trusts at different times. We are asking for something that would be regular, once or twice a week, an update on what is going on sent to a named person in the trust, the senior responsible officer for this issue in the trust, so that we know that it is absolutely being captured.

It needs to be a two-way process. This is not just about communication going out from the centre to trusts. That is why we are asking for NHS trust providers to be treated as an industry group. I mentioned the complexity of the organisation, so consult us separately as an industry group, understand the challenges and make it an iterative process so that we do not have to keep going round all these different loops, can understand together and take things forward.

Things have improved. We sent that letter on 17 August. A week later there was some communication—one of the first communications that came out of the Department of Health and Social Care—so that is progress, and there have been a number more. We need to see it being more co-ordinated and more organised.

Q65 **Luciana Berger:** Thank you. There are two particular areas I want to press you on that were captured in your letter. Have you or your members now been told what level of national contingency planning and support will be provided?



Saffron Cordery: Not yet, no—not formally. Where we are at on that is that there are a number of different risk-planning scenarios going on. The supply chain one I mentioned earlier has only just started. The letter went out on 12 October and responses need to be back by 30 November with the mitigations for the risks. That is when the national support should kick in, once they have had an opportunity to look at that. It is about collecting all this information, processing it and then understanding the assumptions that people can apply to plan on. I would say it is a little late. It is speeding up, but it is still a little late.

Q66 **Luciana Berger:** That would give less than four months before a no-deal Brexit becomes a reality.

Saffron Cordery: Yes.

Q67 **Luciana Berger:** Is there any reason why your members have not been contacted sooner to find out this information?

Saffron Cordery: I think that the collective planning for that started over the summer rather than sooner. I do not know the reasons for that.

Q68 **Luciana Berger:** The second point you asked about in the letter in particular was having some indication of what trusts' individual responsibilities will be. Do your members now have a clear indication of what their responsibilities are?

Saffron Cordery: I do not think that this is yet clear. We are looking at this, because a whole host of different scenarios come into play, which I talked about earlier—emergency preparedness, resilience and response. That is ongoing contingency planning where trusts will put in place scenarios where they can then take control of things, but then we have planning at a national level as well.

What we are not clear about is how those two fit together and where national powers supersede a trust's individual powers, because a trust needs to be clear that it has not just got everything within its control fully taken care of; those interdependencies also need to come into play. It needs to be in control of the whole picture. That is not yet clear, and we are concerned about that because trusts have a duty, as organisations—they have a duty as companies—to safeguard the supply of the services that they provide. They are in a difficult position at the moment.

Chair: We are now coming on to reciprocal healthcare with Paul.

Q69 **Dr Williams:** Tamara Hervey, can you tell us how, in the event of a no-deal Brexit, UK citizens, including those who are either travelling to EU countries or who are resident in EU countries, will be affected by the loss of reciprocal healthcare arrangements?

Professor Hervey: It is important to distinguish between different categories of UK nationals who are in EU countries on Brexit day. In the event of a no-deal Brexit, all the arrangements that we currently enjoy would disappear. A patient visiting an EU country who was in a hospital



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receiving care using their EHIC card would no longer be able to rely on their EHIC card. They would have to rely on the domestic law in the country they were in.

I have not done a comparative study of the entitlements across all 27 countries. All of them will recognise the basic need to emergency care. Again, in terms of reassuring people, it is not that people will be thrown on to the streets because the EHIC card system stops functioning.

UK nationals who are long-term residents in EU countries have entitlements under the EU's long-term residents directive, but that is five-year residence. Their entitlements include entitlements to healthcare on the same basis as nationals of the country they are in. It is only basic healthcare under EU law, so, again, you would be looking at the domestic law to know your exact entitlements. That domestic law might not even be national law because some EU member states have devolved health systems, so your entitlements would be different depending on which part of Spain, let us say, you were in.

One thing we would be facing is a situation of extreme complexity compared with the relative simplicity now. Now, there is a single system that people can understand, there is a single portal that is organised by the European Commission and you can work out what your entitlements are. It might be quite complex for some individuals to have the right paperwork, even now. We would be moving to a situation where it would be virtually impossible for individuals to understand what their entitlements were.

For EU nationals coming into the UK, we are talking about what their entitlements are going to be in domestic British law. That depends on decisions made here about whether the relevant bits of EU law will remain the same under the EU withdrawal Act, in which case entitlements would remain as they are now, or whether they will be changed, and, if so, how will they be changed? Will they be changed through the delegated powers that are given under the EU withdrawal Act, in which case there are questions about scrutiny and so on?

That side of the reciprocal healthcare coin is probably most important for NHS staffing, because one thing that makes it appealing—I hesitate to use that word now—or bearable for people from the EU 27 to come and work in the NHS and social care sector here is that they have entitlements to a whole bunch of things, including housing and education, but also to healthcare. If some of those entitlements were to be changed—for instance, if they were to be treated as ordinary third-country nationals—they would have to pay surcharges for NHS care. All those things could be changed, although they are not necessarily going to be changed. We do not have clarity on those.

Q70 Dr Williams: Thank you. Saffron Cordery, what would the implication be for EU staff working within our health service, of which there are many, if their right to reciprocal healthcare were withdrawn after 31 March next



year?

Saffron Cordery: As Tamara said, that would be a much less attractive prospect. What we are talking about is how we retain our EU workforce in this country, because, frankly, we rely—not entirely, but substantially—on EU and overseas workers in our workforce. In terms of the right to healthcare, the right to other, broader benefits, it is absolutely fundamental to be able to maintain the service that they provide.

Q71 **Dr Williams:** Is the prospect of a no-deal Brexit perhaps weighing heavily on the minds of people? What is happening, for example, to the number of nurses coming to the UK?

Saffron Cordery: There is some interesting trend data on that. The Nursing and Midwifery Council said that between June 2016 and March of this year the number of new EU registrants with them is down 87%. There were a number of factors in that, but one of them is obviously the uncertainty that has been caused by the potential of a no-deal Brexit.

Q72 **Dr Williams:** So there has been a massive decline in the number of EU nurses coming to this country.

Saffron Cordery: Yes.

Q73 **Dr Williams:** What impact is that having on nurse vacancies, for example?

Saffron Cordery: We have an overall vacancy rate of around 9%, which is one of the highest we have seen. We have frontline vacancies of just over 100,000, which is a large vacancy rate, and a proportion of that—I think it is around 10,000 to 15,000—is nurse vacancies, but I am not sure of that figure off the top of my head. We are looking at substantial nurse vacancies. That is just taking one workforce group.

If you then add in, though it is outside my purview, the social care workforce, it would be similarly affected by a no-deal Brexit. We have substantial challenges in a workforce that is already pressurised.

We have never been self-sufficient in staffing in the health service, so that is a fundamental point to make. We rely substantially on a supply of nurses and doctors from the EU. I think it is important to say that there are geographical differences here. London, the south-east and the Thames valley rely on them much more heavily than other parts of the country do.

Q74 **Dr Williams:** Thank you. May I follow up on a couple of things that you said, Tamara Hervey? You said if you are, for example, a UK pensioner who has been living in Spain for the last 10 years, you are likely, under Spanish law, depending on which region in Spain you are living in, to be able to continue to get access to most healthcare, but that if you have been living there for less than five years you will not have that entitlement. Is that right?



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Professor Hervey: The second part of that is right as a matter of EU law. As to the first part, you would not be entitled under EU law, even if you had been living in Spain for 10 years, to anything more than basic care. Your entitlements would depend on what the Spanish decided to give you. Spain is important because there are many British pensioners retired in Spain. There were some indications from Spain that they would want to keep those British pensioners there. The thing that concerns me is the lack of clarity—that there might be these entitlements but there might not be. We do not have a single no-deal preparedness notice on reciprocal healthcare. There is no information on that.

Q75 **Dr Williams:** If somebody is planning on taking a holiday to an EU country next Easter, what advice should they be given?

Professor Hervey: In the event of a no-deal Brexit, we could not rely on the EHIC card.

Q76 **Dr Williams:** They might be given emergency care. You have said that they will probably get emergency care, but they may well be charged for it afterwards.

Professor Hervey: They would be treated on the same basis, yes, as people from elsewhere in the world, not from the EU, depending on where they were going. The practical advice to everybody will be to take out health insurance. Certainly, this Committee heard evidence to that effect and so did the House of Lords Committee.

Q77 **Dr Williams:** My understanding of health insurance is that if you have a pre-existing condition your health insurance might be much higher, so in the event of a no-deal Brexit there will be people with health problems who are not able to get insurance to travel or have to pay phenomenal amounts of money to travel to Europe.

Professor Hervey: Yes. Again, the House of Lords inquiry on reciprocal healthcare found that some people would not be able to access insurance in terms of the products that are currently available.

Q78 **Dr Williams:** We have the Secretary of State coming along in the next panel. Are there any questions that you would like us to ask him about contingency planning over reciprocal healthcare?

Saffron Cordery: There are a number of factors that we need to take in with reciprocal healthcare because it is not simply about whether people can be treated in one country or another. A no-deal Brexit could also lead to a large number of expat pensioners, for example, returning to this country, and this is another issue. There are about 190,000 of those. I read some figures that basically said that, if we were to incorporate them into our health and social care system and treat them, it would probably cost us around £500 million.

It is worth bearing in mind that it is not just about whether you can be treated in one country or another; there are knock-on impacts of that.



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There are also issues such as it is currently part of our referral process that you can refer people to other EU countries to be treated. That, potentially, will be taken out of the tools that we have in our box, as it were, to treat people.

Professor Hervey: May I reply to that? I would suggest that you ask, because there have not been any notices on this, whether there have been any assurances from the EU that, in the event of a no-deal Brexit, arrangements for reciprocal healthcare will be made.

Q79 **Chair:** On the island of Ireland patients are used to being treated on either side of the border. Are you aware of any assurances about the position of patients who travel from one side of the border to the other for treatment in the event of a no-deal Brexit?

Professor Hervey: The situation on the island of Ireland will be covered by the common travel area arrangements and the constitutional relationship between the UK and Ireland and the people who live in Northern Ireland. As to the specific challenges for health—again, I have not seen anything outlining this in any detail—there are questions not just about people crossing the border but about products crossing the border.

Q80 **Chair:** Yes. One issue that has been raised for us is that, if somebody from the EU accesses treatment in the UK, we would continue to offer treatment. There would not be any mechanism then for reclaiming the money from the state that they came from because that currently—

Professor Hervey: That is correct. In the event of a no-deal Brexit, there will be no mechanism for the UK to reclaim those costs. Another question that could be asked of Government is whether there is an intention to change retained EU law that entitles incoming patients to that treatment, because we will be in a situation of paying for it but not being able to recoup it. If so, how is that change going to be made? How is it going to be scrutinised—all of the questions that follow.

Q81 **Andrew Selous:** I have a small question to Saffron Cordery. The Secretary of State told Parliament this morning that there are overall 4,000 more EU nationals working in the NHS and social care since the referendum. Which areas have gone up if nursing has gone down?

Saffron Cordery: I do not know the answer to that question specifically.

Andrew Selous: You are not sure. We will put it to the Secretary of State later.

Q82 **Dr Cameron:** Some of my questions have already been addressed. In terms of workforce, what assessment have health and social care services, particularly those that are heavily reliant upon EU nationals, made of their ability to maintain service delivery in the event of a no deal?



Saffron Cordery: This is essentially around workforce. Workforce has been a massively challenged area for the NHS, even before the EU referendum, so this is a compounding factor. Essentially, we know that the NHS is a long way from being self-sufficient. It is putting in place as many contingency plans as possible, which is about looking at recruiting staff from places beyond the EU. That means overseas from other countries outside the European economic area, but, obviously, that is not that straightforward because when you factor in immigration and migration rules there is not an untapped supply. There are limits. Although the limits have been removed for doctors and nurses, we are also talking about healthcare assistants, social care workers and things like that. It is a challenging scenario.

One thing that I think comes up with this—and we were talking earlier about it—is the additional costs of a no-deal Brexit. It may well happen that as the supply of EU workers dries up we rely more and more on agency staff. That is one area where we have been trying very hard to cut our spending. In the short to medium term, we need to look very carefully at that. We can increase training places—that can be done—but training takes three years, five years and seven years. That is one of the issues.

Q83 **Dr Cameron:** In terms of posts such as healthcare assistants in social care, could we be doing a lot more about increasing self-sufficiency in order to meet the demand?

Saffron Cordery: There are lots of initiatives under way, things such as apprenticeships, nursing assistants and those kinds of roles, but, essentially, over the medium term, we have to make nursing, healthcare and social care a much more attractive profession for people to come into in order to encourage them to do that. That then ties in to a whole host of other issues around terms and conditions, pressures on the frontline staff and that whole web of issues that I will not get into now because there is not really the time.

Chair: It is not the focus of our inquiry today, looking at the existing—

Saffron Cordery: Yes, but those are the factors that we would need to take into account. It is a longer-term issue to make us self-sufficient.

Q84 **Dr Cameron:** The Government announced that the settled status scheme will apply in the event of no deal. Do you have any concerns about that scheme and how it is going to be implemented?

Saffron Cordery: One issue we have had so far has been the uncertainty around settled status. We are just now getting to the point where there is a pilot about to start on 1 November and run through to 21 December for all NHS and social care staff, to look at them actually verifying their settled status through the digital routes. There are some issues with that: it does not work on Apple; it only works on Android. It is a technical issue, but it is quite a big one, actually. NHS trusts are



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thinking about how they can manage that so that people can use Android devices if they do not have them, but, essentially, we do really need to think about that.

We have been discussing settled status since two to three months after the EU referendum. It has taken an awfully long time to get to us this point where we are just piloting for health and social care staff only the settled status application process. That uncertainty has been very challenging for people.

Chair: Time is very limited. We are going to have to move on to our final section on public health with Rosie.

Q85 **Rosie Cooper:** In that case, we will truncate this a bit. We have heard some details in the evidence so far of potentially catastrophic situations. In public health, I want to move to a more general view. There has been considerable progress in public health and the EU has a duty of "Do no harm." The Government have very clearly said that they guarantee no roll-back on the progress we have made. To encapsulate, my question is: what do you see as the key risks to public health, and how confident are you that public health standards in a no-deal scenario will be protected?

Saffron Cordery: There are a number of issues here. One thing that I think we probably all recognise the EU for in terms of public health is around communicable diseases and tracking the flow of communicable diseases. We know that, being a member of the EU, we benefit from early warning on those issues. I do not know what the scenario will be in terms of those networks for early warning. Some of my colleagues might know the answer to that, but that is certainly one area where we need to be very careful. That is how we anticipate what is going to be coming down the track.

Professor Hervey: I can speak to that. In the event of a no-deal Brexit, the UK will immediately be excluded from the European Centre for Disease Prevention and Control. The Faculty of Public Health has issued a document with, I think, 64 others setting out what the preferred outcomes would be. The No. 1 preferred outcome is to be a full member of the ECDC, and they have calculated the cost of that.

Alternatives include negotiating a bespoke Switzerland-type arrangement with the ECDC. Time will not be on our side for that. The third option is some kind of bilateral arrangements with the ECDC, the international health regulations and so on.

In the event of a no-deal Brexit there will be a period before any of those things have been done. During that period, logically, we would not have the benefit of the information that comes through those systems.

Q86 **Rosie Cooper:** Basically, we have no confidence that those standards will not roll back.



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Professor Hervey: It is very difficult to see how the undertaking that the Government have given to “do no harm” could be fulfilled in the event of a no-deal Brexit.

Rosie Cooper: That is very scary.

Chair: Thank you all for coming this afternoon and for bearing with us while we had a long pause in the proceedings. If there are any other points on which you feel you would like to give us further evidence, please send that to us.

Examination of witnesses

Witnesses: Matt Hancock and Sir Chris Wormald.

Q87 **Chair:** Good afternoon. Thank you both for coming. Secretary of State, you are well known to people following from outside this room, but, Sir Chris, would you mind explaining what your role is?

Sir Chris Wormald: Yes. I am Chris Wormald, Permanent Secretary at the Department of Health and Social Care.

Q88 **Chair:** Thank you very much. We are here this afternoon to look at the state of contingency planning in the event of no deal. We started with our last panel considering the implications for pharmaceuticals and medical devices in particular.

Secretary of State, one thing that will most concern people watching is: how well prepared are we, in the event of no deal, to make sure that products are on the pharmacy shelf when people arrive with their prescription? We know, for example, of the shortage of EpiPens because of an issue in the manufacturing supply chain. The implications of that happening across the piece in a number of different products would be enormous, both for individuals and for the entire healthcare system. Will you give us a picture of where we are now with all this?

Matt Hancock: Thank you, yes, and thanks for the opportunity to return to this issue. Clearly, we are focused on it very closely in the Department, and indeed we discussed it at Cabinet earlier today because it is obviously a cross-Government issue.

The situation is that we do not expect a no-deal Brexit. That is our central expectation, and I remain optimistic that we will be able to get a good deal. Nevertheless, as a responsible Government, we ought to be preparing even though we do not see a no-deal Brexit as the most likely outcome.

Engagement with the pharmaceutical industry has been very positive. There is an awful lot of engagement and yet more that needs to be done. The plans that I talked to the Committee about in July are proceeding. I am confident that if everybody does what they need to do we will have



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the unhindered flow of medicines and supply of medical devices that we want to see.

We have published a series of technical notices to support the actions that will be needed in order to see that happen. We need to make sure that we in Government do what is necessary to support the unhindered flow of medicines in the event of no deal—and that the pharmaceutical industry does so—and that the NHS is prepared. I stress again, as I did the last time we met on this subject, that it is the responsibility of the pharmaceutical industry—of course, supported by the Government and the NHS—to deliver on the contracts that they have. Having said that, we are working very closely with them and are prepared to support them to make that happen.

Q89 Chair: Secretary of State, it is 157 days now until we are set to leave. We heard that some of the contingency planning, for example, around refrigerated warehousing, would take a year to construct. Time is not on our side. How confident are you that people will find that they have the medicines that they need on the shelf and that hospitals will have the complex biologics and other diagnostic tools they need?

Matt Hancock: I am confident that, so long as everybody does what they need to do, we will have that unhindered supply of medicines. However, an awful lot of things need to take place. You mentioned, for instance, the storage needs and the need to stockpile. We have issued today an invitation to tender for additional storage capacity. The storage capacity we are looking for is either additional storage that is ready for Brexit-related demand or space that can be converted to medical storage or the new facilities that you talk about.

We are confident that that can be delivered in time for March next year, hence we are getting on with it even while we are proceeding with the negotiations, which I very much hope will lead to a deal and to there being no need for this stockpiling. We are getting on with making sure that we have the plans in place, and we are taking the actions that we need to take now in order to have the mitigations in place.

Q90 Chair: Have you made an estimate of the total costs, because there are costs in very many areas, as we heard from our earlier panel, not just in storage capacity but right through the entire system in switching the way BSI may need to switch to different European certification bodies in the devices chain. In every single area—every part of the supply chain—there are issues. Have you made an estimate of the cost?

Matt Hancock: The cost to taxpayers is related to the additional support that we will give to industry to ensure that they can have that unhindered flow of supply. We are not going to double-pay for medicines. There have been some figures bandied about that simply add up the total cost of medicines that need to be stockpiled and say that that is the cost of medicines in a no-deal scenario. That is not the case, because we buy the



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medicines once, and if they have to be stockpiled for a period there is a storage cost to that.

Q91 **Chair:** Yes, but there is an up-front cost.

Matt Hancock: Exactly.

Q92 **Chair:** There are other costs in terms. We heard, for example, of bringing on a greater capacity for refrigerated lorries and warehousing at every stage. Industry is not clear about how they are going to be reimbursed for those extra costs. They are particularly concerned about the impact on small companies.

Matt Hancock: Yes.

Q93 **Chair:** How are you going to make sure that we do not see smaller companies going under because they are having to bear the extra up-front costs? At the moment they have no certainty about how they are going to be reimbursed and when.

Matt Hancock: Yes. We want to ensure that the support that goes from taxpayers for this is as well targeted as possible. As you say, the bigger suppliers in many cases were already undertaking this sort of activity before we announced that we potentially had support available. The ITT that has been published today will lead to costs that we expect to be in the low tens of millions of pounds to the taxpayer. I do not have an exact figure for it because we are buying this storage capacity from the market, and in some cases it will be constructed. Of course, we will be transparent about those costs once we have made agreements, but we do not have a figure in advance because we want the costs to be as low as possible.

Chair: I understand that, but—

Sir Chris Wormald: I can add something, maybe helpfully. What we are doing right now is almost a product-by-product discussion with industry following the Secretary of State's letter in August. The industry comes back to us with a lot of information and then we are discussing with them what the right answer is, basically, at individual product level. For some people that will be stockpiling, and there may be some where you need to do air freight for some of the reasons that you have described. We will not take decisions on individual support until we have completed those discussions. With a lot of these questions, it is quite difficult to give a generic answer because we have to be working down at the level of individual products.

Q94 **Chair:** Indeed, but we heard that a number of companies are now having to invest quite heavily in contingency planning. If they are small companies with tight cash flow, that has very serious implications for them. Are you, on a company-by-company basis, discussing with them how they can be kept afloat and supported through this process?



Sir Chris Wormald: Yes. These are the discussions we are having. I am sure you heard a lot of this from witnesses, and it goes throughout our preparations, that there is a big desire from industry for certainty across a whole range of things. The nature of where we are and the possibilities of no deal mean a whole series of things. We are not able to give the certainty that people want. We think we have the right processes to deal with that, but we cannot get away from there being an underlying uncertainty.

Q95 **Chair:** But is your contingency planning also factoring in that some companies may go under or simply move abroad?

Matt Hancock: Companies will need different support on a drug-line-by-drug-line and a company-by-company basis, depending on the scale of the company. We have already seen a swifter reaction generally by the big companies, although some small companies have also been able to move quickly. You cannot give a general answer to that. There are over 400 of these companies with whom we are engaged. We have a team in the Department doing that engagement, but the instruction I have given to the civil service team doing this is to ensure that for every single line we have a plan in place that is appropriate to the medicine—for instance, some of the shorter shelf lives need different treatment—and consistent with cross-Government planning assumptions for the timescales involved.

Q96 **Chair:** If they come back to you and say, “We are facing up-front costs preparing for a no-deal scenario,” because they have to get on with that now given the lead times involved, are they going to be directly reimbursed, or how do you envisage the mechanism for reimbursement?

Matt Hancock: We have that discussion on a company-by-company basis because we want to protect value for money. It is very important that this process is not gamed and that we make sure that companies are appropriately supported—that that support is available if it is needed—but we get into quite a level of detail. Most of these companies are long-term suppliers to the NHS, so we can have a relatively open-book discussion with them. They want to be long-term suppliers to the NHS in the future. We expect a collaborative approach, and that is what we mostly have.

Q97 **Chair:** Thank you. It certainly did not come across from our first panel that there was certainty about how they were going to be reimbursed, I have to say.

Matt Hancock: Neither of us has said that.

Q98 **Chair:** No, but you have said that there is case-by-case, product-by-product discussion going on. That was not the impression that we were given—that they had any clarity about how they were going to be reimbursed.

Matt Hancock: I am sure for a company in these circumstances it might be easier if we simply wrote a cheque, but we are not going to do that because we want good value for money for the support that we give.



Q99 Mr Bradshaw: Secretary of State, you could have avoided a lot of this cost and disturbance if you had gone for a Norway-style option in the first place, could you not? That is what the industry said to us last year—full regulatory alignment, the customs union and a single market. Is it inconceivable that you might change your minds as a Government and reach that sensible option in the next few weeks?

Matt Hancock: I think we have a good deal on the table, which, as the Prime Minister said yesterday, is 95% agreed in terms of the withdrawal agreement. I am confident that we will be able to land that deal, and that deal includes the sorts of associations in terms of medical supplies that will allow us to be very close to our European partners over the long term.

There are lots of different views on exactly how Brexit should be put into place, or indeed whether it should be at all. My view is that the plan that the Government have put forward will give us a good Brexit deal and I am confident that we will get there.

Q100 Mr Bradshaw: It is very close, but it does not provide the full regulatory alignment that the industry has said time and again that it needs, does it?

Matt Hancock: It does provide for full regulatory alignment at our choice. We want to ensure that there is no reason why it should be more difficult to apply for licences than now. Indeed, in some instances, it may be possible to accelerate the process. Today we have launched, for instance, the accelerated access collaborative. This is not a Brexit-related policy, but it is about accelerating access to new innovations across the NHS. Moving to an MHRA-led process gives us the opportunity to do that.

I understand that lots of people have concerns, but the reassurance I give is that we are going to ensure that new drugs under a deal or no-deal scenario have a passage through the regulatory system with no more burdens than in applying to the EMA.

I think we can have an excellent system for drug regulation in the future. We have already set out in detail how we are going to ensure that we recognise batch testing done by the EMA, and we have a consultation out right now on how we can ensure that those who apply to the EMA can apply in the same terms to the UK regulator. I hope I can give some very significant reassurance that it will be just as easy to apply as now, if not more so.

Q101 Mr Bradshaw: A moment or so ago you said that you were “confident”—that was the term you used—about the continued supply of vital medicines and medical equipment in the event of a no-deal Brexit. That is not language that Sir Chris would use in front of the ExEU Committee last week. I wonder why you are more optimistic than he is.

Matt Hancock: Funnily enough, we discussed this before arriving and both of us say exactly the same thing. I will say it and then why don't



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you say it? We are confident that if everybody does what they need to do we will have the unhindered supply, and I am satisfied that everybody currently is doing what they need to do. There is a huge amount more effort that is needed between now and the end of March should we be in a no-deal scenario, but I am confident that we can get there.

Sir Chris Wormald: Yes. When I was discussing this with the Exiting the European Union Committee last week, I was actually making a more general point, that I almost never use the words “guarantee” or “confident” to do with anything in health. It is a very big and complex system in which a lot goes right and some things go wrong. As a general rule—and this is the point I was making—I do not do that.

As the Secretary of State says, if everyone does what they need to do, we should be in a good place. The uncertainty, which again we discussed at the Exiting the European Union Committee last week, is around not what the Government are doing—I am completely confident that the Government are doing all the right things, as you would expect—but the issues we were discussing about what the French reaction would be, which obviously we do not control. That is where the big uncertainty is that you will see both from the industry side and from outside.

Q102 **Mr Bradshaw:** I noticed that, in spite of the prompting you just received from the Secretary of State, you were not prepared to say that you are confident.

Sir Chris Wormald: No. I am confident that the Government are doing all the right things and that, if everyone does what they are supposed to do, everything will work. That includes the uncertainty around how the French will react. I said to the Exiting the European Union Committee last week that everything we have seen in the discussions is that health has not been a vexed issue across us and our partners, and everything we have seen suggests that everyone, both here and in the EU, wants to ensure that vulnerable people are protected and nothing goes wrong. If that continues, as I say, and everyone does the right thing, as the Secretary of State has said, all these issues ought to be mitigable. I would completely endorse what the Secretary of State has said.

Q103 **Mr Bradshaw:** Is your advice to the industry still that it will require six weeks of stockpiling to ensure the continued supply of medicines and medical devices for NHS patients?

Matt Hancock: Yes. That is our advice as set out in the technical notices based on a cross-Government assessment. We, of course, always keep that under review.

Q104 **Mr Bradshaw:** Might that change?

Matt Hancock: We keep it under review and we set out when we publish the technical notices that we will keep it under review according to the assumptions that feed into the decision on for how long there might be blockages.



Q105 **Mr Bradshaw:** On what is that six-week assessment based?

Matt Hancock: It is based on the cross-Government assessment, including from the Foreign Office, the Department for Transport and the Cabinet Office assessment of what the timescales should be.

Q106 **Mr Bradshaw:** So it takes into account what the Department for Transport has said about the likelihood of the M25, or whatever it is called—the one that goes to Dover—becoming a lorry park.

Matt Hancock: It takes into account all these things. It is a cross-Government planning assumption, and that is kept constantly under review. That is the central assumption of the length of time that we need stockpiling for. Of course, there are many other detailed planning assumptions that are being worked on to ensure that we have as good a plan as possible. There are two elements to the civil contingencies work, both the plan in advance and then ensuring that we have a smooth-as-possible system in place for reacting to events as they occur in the event of no deal.

If we are going through a no-deal Brexit, a series of changes will occur as we leave the EU and we will need to be able to respond to those. That machinery is in place and it is based on existing procedures that are operated when there is a civil contingency issue.

Q107 **Mr Bradshaw:** The six weeks implies that you are confident that within six weeks of a no-deal cliff-edge Brexit you would be able to establish completely alternative supply chains for all the stuff we need, because the stuff in the warehouse is going to have run out by then.

Matt Hancock: The six weeks is the planning assumption for how long we will need stockpiles of medicines before we are able to resume supplies either because the blockages at the border are relieved or there are other routes in place. For instance, for short-life isotopes, in that period we will switch to airborne supplies—we will have to because you cannot get them in quickly enough if there are blockages at the border. Likewise, there is work ongoing on the alternative ways of ensuring that there are supply chains, even in the event of a continued blockage.

Q108 **Mr Bradshaw:** We heard earlier from one of the industry witnesses that you are going to have to use emergency powers to allow pharmacies to change patients' drugs without the consent or consultation of their GP. Is that something you are aware of and are planning to do?

Matt Hancock: That is not something that I am aware of, other than this. There is a normal procedure—as demonstrated now with the shortage of EpiPens, which is because of an issue to do with their manufacture that is completely unrelated to Brexit—which demonstrates that with the UK's system we constantly have a series of shortages of different types of medical equipment or drug. That is normal. In fact, when I asked, "When did we last not have a shortage?" I did not get an answer, because it is a standard situation that there is a shortage of one



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or other pieces of equipment or drug. The response to such a shortage can be both to look for alternative supply lines and to take a clinically based decision on the appropriate reaction to the fact that whatever it is may not currently be as available as we would like. This is part of the Department's work that is in constant use and constantly being tested.

Q109 Chair: Secretary of State, may I make one observation to you? As a clinician before I came to Parliament, I know that being on the receiving end of that kind of thing takes up an inordinate amount of clinicians' and pharmacists' time chasing round for alternatives. It is okay when it happens occasionally with one or two products, but if it is on a grand scale, and it is happening for many products all at the same time, that is, I think, what concerns a lot of people.

Matt Hancock: We are trying to reduce the number of products with which that will happen with all the planning work that we are doing now.

Q110 Andrew Selous: May I return to the issue of cold storage? In the last session we learned that half the new medicines licensed last year require cold storage. We also heard the point that the Chair made earlier that we were told it currently takes around a year to get new cold storage up and running. You may have given an answer when you mentioned that we would have to get isotopes in through airborne means, but is that part of our planning assumptions for those medicines that require to be refrigerated through their entire distribution process from manufacturer to the patient?

Matt Hancock: Not necessarily, no. The airborne route is mostly but not entirely focused on short shelf life, especially isotopes that degrade—those drugs or treatments that you cannot stockpile, essentially. We can use refrigeration for drugs that you can store. I do not accept the point of evidence that both you and the Chair have raised as a premise that it takes a year to put up refrigerated sheds, not least because we can use now additional storage that is already existing. That is part of our tendering. We can convert space to medical storage standards that currently is not that standard and you can build new facilities. It may be the case that somebody has had an example of where it has taken a year, but you can do it quicker.

Q111 Andrew Selous: Okay. That is helpful. Thank you for that. Quite a lot of our previous discussion focused on the issues surrounding current British standards and European standards and how that would work in the event of no deal. That was a particular concern raised by Johnson & Johnson. What is the Department's thinking on how we deal with UK certification and EU certification, not least in respect of the 46 million items of medicines that leave the UK to go into the EU as well as, obviously, the 37 million items that come into the UK?

Matt Hancock: Is this under no deal or a deal?

Q112 Andrew Selous: Under a no-deal scenario. I think it is going to need legislation as well, and I do not know whether you want to say anything



on that.

Sir Chris Wormald: I gather Johnson & Johnson were raising an issue particularly around stitches, which I have to say I do not have a specific answer to, so I will take a look. The general principle we are working to is anything that is currently licensed in the EU we would license in the UK in any circumstances. The other way around is obviously not under our control. In a no-deal situation, what the EU chooses to license or not license in terms of UK products is—

Q113 **Andrew Selous:** I am sorry, so does that licensing within the UK require legislation, and what is the timescale? We can pass it on if—

Sir Chris Wormald: I do not think it requires legislation. As I say, I will check the specific case.

Matt Hancock: The legislative requirements will be dealt with under the EU withdrawal Act because the Act provides for us to change a requirement for EMA regulation to a domestic regulation, which would be done by MHRA. So, we have the provision in place for those legislative elements that are needed, but the central point is this: we will effectively unilaterally recognise EMA approvals and EMA batch testing to make sure that there is no barrier in this space.

Q114 **Andrew Selous:** Is that a Secretary of State power—that you can recognise that?

Matt Hancock: Yes. We will align MHRA processes so that people applying for a new drug in future will not have any additional burdens to apply for MHRA licensing. It will have to be MHRA licensed because the power would come to a UK organisation, but we will make sure that the process is aligned so that somebody going for an EMA approval will also be able to go for an MHRA approval, and we can do that unilaterally as well.

Andrew Selous: Okay, that is helpful.

Matt Hancock: I want to give the maximum possible reassurance to pharmaceutical companies that are interested in this area and may be watching. My maximum possible assurance is this: if your drug can be approved by the EMA, then it is going to be approved in the UK under a deal or a no-deal scenario.

Q115 **Andrew Selous:** I am sure that will be very reassuring, not only to people in the room but to those watching from outside.

The last area I want to raise is this. I was a little surprised to hear from Saffron Cordery of NHS Providers that there has been some reference to possible difficulties around feeding patients in hospital. She said this had been mentioned in some of the technical notes. Can you give us some reassurance on that issue?



Sir Chris Wormald: We had a communication with NHS hospitals asking them, basically, to check all their contracts for any EU exit issues. We provided them with a toolkit to do so. Food is one of the areas we are doing centrally rather than asking individual hospitals to do it. We are asking centrally all the main suppliers of food to hospitals to ensure that they have contingency arrangements in place for anything that they currently source from Europe. That is a discussion that the Department is having. I suspect that is what she was referring to.

Q116 **Andrew Selous:** The issue also covered nutritional supplements.

Sir Chris Wormald: Yes. I was reading the letter just before I came in. There is a colossal list of NHS suppliers to whom we are asking the same questions. There is nothing specific about food. We want to ensure that we have asked that question about the vast range of NHS suppliers, either nationally or trust by trust. We were dividing out, "These are the ones where we are going to have a conversation nationally," and, "For anything else, you need to be having a local conversation."

Q117 **Andrew Selous:** You said earlier that health is a tricky business, and sometimes you do not like using the phrase "I want to give complete reassurance," but what words would you choose to give to some families listening who know they are going to have loved ones in hospital next year to reassure them that they are going to be fed?

Sir Chris Wormald: It seems to be everyone's favourite question. We are clear that we are putting the right mitigations in place. I am not going to predict the future and I never do, but the Government have put in place all the right measures to ensure that we can manage these situations.

As the Secretary of State was saying, pretty much any contingency in the health service has two parts: it has a prepare bit and a respond bit. We think we are in the best place we can be to do both those things, but the latter—the respond bit—as with any other piece of contingency planning, has a level of uncertainty to it. We can be completely confident that the Government are taking all the right steps, but one of those steps is to be prepared for things that we do not know are going to happen yet.

Q118 **Martin Vickers:** Secretary of State, you referred earlier to what the Prime Minister said yesterday about a deal being 95% complete. In the remaining 5%, what issues concerning your Department are there?

Matt Hancock: I want to give you as full an answer as possible. As far as I can consider, other than the position of the Irish border, which is clearly one of the trickier remaining issues over which there is a small flow of medicines, I do not think there are any, and there are certainly none that are health-specific where the main incidence of the concern is around health.

Q119 **Martin Vickers:** The previous panel expressed some concern that the EU 27 were not engaging in detailed discussions because of some



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substantive issues.

Matt Hancock: Not substantive issues to do with the responsibilities of the Department of Health and Social Care.

Q120 **Martin Vickers:** I have one last question. Is the position of UK citizens receiving health treatment when in the EU 27 now resolved?

Matt Hancock: Yes. It is resolved under a deal scenario so long as we land a good deal. In a no-deal scenario, we will publish very shortly a healthcare reciprocal arrangements Bill. We are undertaking bilateral discussions with the main countries in which UK citizens reside and whose citizens live in the UK to get to a position where people's health is looked after wherever they live.

Martin Vickers: Thank you.

Q121 **Chair:** If you have no further follow-up points, Ben, I turn to the point about regulatory alignment.

The Committee has in the past welcomed having regulatory alignment for the reasons that you set out. In the event of no deal, would it be the Government's intention to continue with regulatory alignment from our end, just to be absolutely clear on that point?

Matt Hancock: Yes.

Chair: Thank you. That is very helpful. We are going to move on now to further points on contingency planning, Andrew, or have you had all your questions answered?

Q122 **Andrew Selous:** I have more points on staff, if it is worth coming on to them now.

Secretary of State, you told us in Health questions earlier today, if I heard you correctly, that there are 4,000 more EU nationals working in the NHS and the social care system than at the time of the referendum, but we heard in the earlier session that the number of nurses applying to work in the UK from the European Union countries has declined quite severely. Could you just give us a little more detail of the breakdown? It is a net overall increase, but it has gone down for nurses. Could you fill in the remaining gaps in terms of what is happening, please?

Matt Hancock: Yes. I said more than 4,000 on the Floor of the House earlier because I did not have time to turn to this page of my briefing, which says that the increase in EU staff in the NHS from June 2016 to June 2018, which is the latest figures I have, is 4,367. That is an increase of 580 doctors, 205 ambulance staff, 1,618 scientific, therapeutic and technical staff and 1,910 support to doctors, nurses and midwives. The nurses, health visitors and midwives number has fallen. At the same time as the referendum, we introduced stronger language testing. My analysis, having looked into this in depth, both implied by these figures and once you dig into why the number of applicants from the EU for nursing places



in the UK has fallen, is that it is due to the impact of the language testing rather than the impact of the referendum.

- Q123 **Andrew Selous:** Obviously, having enough nurses on our wards is absolutely critical to everything we do in the NHS, and we know there is a significant need in that area now.

Matt Hancock: Yes.

- Q124 **Andrew Selous:** I know immigration policy per se is not in your particular brief, but could you say as much as you are able to in front of this Committee about how you envisage post-Brexit immigration in respect of health and social care needs in the UK in so far as the EU 27 countries are concerned?

Matt Hancock: Yes. Our proposal is that we are going to have a global skill-based immigration system. We currently have an exemption, an uncapped system for attracting doctors and nurses from the rest of the world outside the EEA, which I think is great. I want to see the brightest and the best doctors and nurses from around the world continue to come to the UK, as they do now.

The language-testing point is a matter for the Nursing and Midwifery Council rather than the Department, and they are independent, but there is a need to attract doctors and nurses from around the world, as there always has been in the past.

- Q125 **Andrew Selous:** Okay. I am very pleased that you are very keen on technology as Secretary of State. We learned earlier from the deputy chief executive of NHS Providers that there is an issue that settled status cannot be applied for on Apple products. Are you in the course of being able to sort that out? Apparently, you can apply for it on Android products but not Apple ones.

Matt Hancock: You can also apply for it on a desktop computer. I have talked to Home Office officials about that. There are lots of different ways that you can make the application, and the application is relatively straightforward. If, like me, you have an Apple device, you need access to a different device or a desktop.

- Q126 **Andrew Selous:** You will make sure that this does not become a problem in resolving settled status—you will keep an eye on the fact that EU staff who need to go through this process can do it in a timely and straightforward manner and that there aren't bottlenecks and delays, because, obviously, that will just add to anxiety.

Matt Hancock: On this one, I am happy to take instruction from the Committee.

Sir Chris Wormald: The only thing I would add is that it is mainly Home Office business, but they have been trialling their settled status systems mainly in the NHS and in universities and are going to continue to do so. They have been very clear that the NHS is one of their key customers



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and are, therefore, testing all these systems in trusts—we have been testing in Liverpool and we are going to go on testing in some other areas—so that we are sure that it works for the NHS as well as all other groups.

Q127 **Andrew Selous:** Do you know if they are trying to get it to work on Apple products, and are you asking them to do that?

Sir Chris Wormald: This will go rapidly beyond my technical expertise, but, as I understand the issue, it is about what Apple is prepared to support as opposed to what the Government are doing. I know the way that a number of NHS trusts have been dealing with it is just to make sure that Android devices are available in the hospital to ensure that all staff have availability. There are a lot of Android machines out there, and there are things that employers can do to ensure that there are no technical barriers, in the way the Secretary of State has described.

Q128 **Dr Williams:** You are a Secretary of State who likes to ask questions of your officials. You often refer to the questions that you ask.

Matt Hancock: Am I?

Sir Chris Wormald: Yes, you are.

Q129 **Dr Williams:** You must have asked the question around not just the number of staff who are coming from EU countries into the NHS since the referendum but the rate at which those staff are coming here. You have said today that we have 4,367 more staff than in June 2016. You previously said that there are 1,300 more staff than in March 2017. If you work out the rate from the numbers you have given, in the first nine months after the referendum there were 356 people a month coming, but since then there have only been 81 people a month coming. If you say that the language test was applied at the time of the referendum, in the nine months after the language test was applied there were still 356 people a month coming. It is since March 2017—it is the recent figures—that there has been a massive decline. There has been a 77% reduction in the number of people coming. That has to be because of the Government's mishandling of Brexit. We all know it; it is all on the ground. When we listen to people from European countries, they do not want to come here because they are afraid.

Matt Hancock: That is not my reading of it because you have lumped in or compared apples and pears in that. The change in the language requirements only applied to nurses from the NMC, and nurses, health visitors and midwives is the only category where the number of EU employees has fallen. It has risen in every other category, whereas the way you described the figures, first, was describing the totality of EU employees and then, the second time round, referring to the language requirements, which have only applied to a subset.

My analysis of all the figures rather than a partial set is, given that the numbers everywhere else have gone up but in the one place where we



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have applied an additional—well, the NMC has applied—language test, the figures have gone down. There is a straightforward logic to that and that is confirmed by diving in to ask the questions of why the numbers have changed.

Q130 Dr Williams: Do you accept that there has been a 77% reduction in the rate of people coming?

Matt Hancock: I have the 2016 and the 2018 figures in front of me. I am happy to write to you with a more detailed breakdown of the statistics.

Q131 Dr Williams: Would you be concerned if there was a significant reduction in the rate of staff coming here from EU countries?

Matt Hancock: I am keen to ensure that we can, as we always have, attract the brightest and the best people from around the world to work in our NHS. We have to remember that the majority of non-UK nationals working in the NHS are from outside the EU. Sometimes this debate takes place as if the UK and the rest of the EU were the only places on earth. That is not the case and we attract many brilliant professionals, both clinical and non-clinical professionals, from all over the world. They are extremely welcome and our NHS benefits from them.

Q132 Dr Cameron: Yes. Will EU staff who have lived in the UK for less than the five years be eligible to apply for pre-settled status?

Matt Hancock: The settled status policy is a Home Office policy, so I do not want to give an answer without looking at the details of it. You might want to ask the Home Office.

Q133 Dr Cameron: Can you perhaps write to the Committee or find out?

Sir Chris Wormald: Yes. I will give you my understanding, but I may need to correct it once I have checked the actual position. As I understand it, there is a time limit on when you can apply for settled status, but not an end point. If you are here, you can apply at whatever point you reach the relevant check point. I do not know if it is five years.

The Prime Minister has made very clear what she said about people who are already here and working in the NHS and elsewhere. I will check the exact technicalities. That is my understanding of how it works.

Matt Hancock: My briefing note says that the Home Office has launched the EU settlement scheme, a simple registration process for EU nationals who arrive in the UK to live before the end of 2020 or 29 March 2019 in the event of no deal to remain living in the UK with broadly the same rights as they currently enjoy. The Home Office tested this scheme with all health and social care staff from 26 November 2018, giving them earlier access than the rest of the population.

That is my understanding. I did not recognise the five years' point. That states that everybody living here will be able to apply for settled status.



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Q134 Dr Cameron: I have a quick question about social care staff, because when we move from health to social care it is going to be a huge priority to get this right in the future. As well as making sure that social care staff can stay and work, what are the Government going to do to try to ensure that we train enough staff here to become social carers and that we provide opportunities for people in the UK to take on that really important role?

Matt Hancock: I think this is such an important issue. I want to make sure not only that we provide for the training that people want to work in social care but that we increasingly make the roles in social care really attractive. That is the case in some providers, but it is not always the case across the board. We have a whole strand of work in the Department for making the jobs in the health and social care system more attractive and yet more rewarding. Too often the jobs are rewarding and mission-driven because you are helping other people, and that is very rewarding, but, despite the system. I want to see the system support rather than get in the way of people loving their jobs.

Q135 Chair: Thank you. We know that there are 104,000 roles in England, and that 8% of the total workforce in social care are EU nationals. Obviously, their income is going to fall under any kind of level where they would automatically be able to apply to come here. Are you concerned about the impact on social care and people who use social care after we leave the European Union of making it more difficult for people to come here?

Matt Hancock: Like the NHS, there are more people from outside the EEA than from non-UK EU and EEA countries working in social care. Again, our approach has to be global. Part of the answer is more training domestically so that people can support the system.

Q136 Chair: Yes, I think we would all agree on that, but there is going to be a shortage. One reason why it is so helpful to have staff from the EU is the ease with which they can come here. Have you made an estimate of the extra costs that will be faced by the care system and the NHS in the visa arrangements involved? There will be a significant extra cost.

Matt Hancock: I do not have a specific estimate of the visa costs involved. Visa costs have not been set and the immigration policy and White Paper has not yet been agreed, but it is something on which I am working closely with the Home Office.

Q137 Chair: Have you made an assessment of how long it takes to facilitate staff coming from outside the European Union as opposed to the EU?

Matt Hancock: Part of what we want to do with the future immigration system is make those timescales shorter and easier because there is the direct financial cost of getting a visa but also the bureaucratic time that it takes.

Q138 Chair: You are intending to look specifically at how you can reduce that.

Matt Hancock: The bureaucracy around getting visas, yes.



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Q139 **Chair:** Have you had any discussions with your colleagues in the Home Office, because the change to the tier 2 visa arrangements—that they are uncapped—was very welcome, but that is time limited, I understand. Do you know for how long exactly?

Matt Hancock: No, it is not. The Home Office answered a question in the standard way that they do, which is that all visa arrangements are kept under review. That was interpreted to mean that this was a temporary scheme. We have no intention of changing it.

Q140 **Chair:** Thank you. Earlier, you seemed to indicate that the drop in applications is primarily due to language testing. There is no doubt that that had an impact, but during our nursing workforce inquiry this Committee heard more than once from nurses in tears telling us how they no longer felt welcome working in the UK. Do you accept that the decision to leave has also had an impact on applications from the EU?

Matt Hancock: Like everybody, I have heard stories like that and I hate the fact that some people have felt less welcome here following the result of the referendum. I want to welcome people who want to contribute, in an appropriately organised way, from right around the world. Of course I have heard the same stories.

Q141 **Chair:** Was that directly from individuals? Have you been out and met staff from EU countries?

Matt Hancock: I know there are people who feel like that. I am trying to think of whether somebody within the NHS has said that to me directly, but I know that people feel like that. I hope that one thing that we can do as we land a deal is bring people back together across society. Everybody needs to work on that together, and the NHS can play its role as a really big employer.

The fact is that the figures speak for themselves. Even though there are people who absolutely express those concerns, there are more people in the NHS from the EU than there were on the day of the referendum. I think that shows that, overall, we remain an extremely attractive place to work.

Q142 **Chair:** I agree, but we need to look at those figures in the context of the total employed population in the NHS, not just as absolute numbers, and the rate, as my colleague has mentioned.

Matt Hancock: Of course. I am an internationalist. I love the fact that we attract brilliant people here to the UK and I think it adds huge value. I think it is best that that is done in a controlled and organised way, but there is a lot of value that can be added, and, most importantly, when people have come to make a life here they should feel welcome. It is incumbent on all of us to play our part in that.

Q143 **Rosie Cooper:** The Government have indicated that public health protections and standards will not be traded away and that health



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partnerships will remain strong.

Matt Hancock: Yes.

Q144 **Rosie Cooper:** Yet the last panel told us that in a no-deal scenario the UK will be immediately excluded from the European Centre for Disease Prevention and Control. All that means, potentially, that UK residents are exposed to additional risk. I further understand that an EU-wide prescription medicines verification system—the falsified medicines directory—is due to be rolled out in the UK in February 2019. What will happen to that system if there is no deal? Will we become more vulnerable to counterfeit medicine?

Matt Hancock: No, for two reasons. First, we will still be members of the EU when that scheme becomes law directly applicable from Brussels. Secondly, although some European countries have a problem with counterfeit medicines, we do not have a large-scale problem and the existing system works, largely, very well. To take a leaf out of my Permanent Secretary's book, I would not guarantee that there are no counterfeit medicines at any point, but in the UK the figures show it is a very small problem, and we are determined to keep it that way.

Sir Chris Wormald: Shall I answer on your more general point about health protection? Health protection is already a world business. Our dealings internationally are partly through the EU, as you say, but they are also heavily through the WHO, of which we remain and will remain a leading member. In practice, if the result of exiting the union is that we are not involved in EU systems, we will have to rely more heavily on our WHO systems. The WHO has a European level of activity that actually goes wider than the EU, of which we will remain a member. We will have exactly the same objectives for health protection, but we will have to deliver them differently and use, as I say, our WHO membership more heavily if we do not have access to the EU one.

Q145 **Rosie Cooper:** Slow down. Would it be diluted?

Sir Chris Wormald: No. We will do what everyone else outside the EU does, which is work with the WHO. Much of our health protection work is already with the Americans and the Canadians and so on, and we will have to rely more heavily on those systems.

Q146 **Rosie Cooper:** You are really saying there will be no disadvantage.

Sir Chris Wormald: We will have to ensure that there is not. As I said earlier, with all these issues around health, there is no difference of alignment between us and our European partners; there is no advantage to anyone in not co-operating on health protection on those sorts of issues. We will have to do it in different ways and in different formats, but, as I say, we envisage—and, as I said before, I hope this will continue—continuing to have a productive relationship with all our international partners, regardless.



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Q147 **Rosie Cooper:** Obviously you have had discussions with Europe on these matters. What have they said?

Sir Chris Wormald: As I say, the discussions around health have not been that prominent or that vexed around these questions. Obviously, everyone's focus is on getting the right multilateral deal at the moment, so our discussions about what would happen if that does not work have been limited, but we would expect everyone to share the same objectives as us.

Q148 **Rosie Cooper:** But what if your expectations are not met?

Sir Chris Wormald: As I have said, you respond to those circumstances. In the specific area that you are raising of health protection, there has always been—not always, but since its creation—a world system around the WHO, so we know there is an effective system that we already are a major part of that we can play into. So, in that specific area it is very clear what we would do. As I say, we would rely on our very active membership of the WHO.

Matt Hancock: If anything, the Permanent Secretary is underplaying the role that the Department plays globally on this. Our chief medical officer is one of the leading figures in global health issues. There is absolutely no way that Brexit is going to change that.

Q149 **Chair:** Secretary of State, I know you have to go, but will you respond to the comments in the letter by a galaxy of Nobel Laureates that Sir Paul Nurse was discussing on the radio this morning and give us an idea of how you are going to ensure that after Brexit our research community is not devastated?

Matt Hancock: Yes. I am absolutely determined to do that. I saw the letter. The core part of the letter, the core argument in it, was that we should get a deal. I very strongly agree with that.

Chair: Yes. I think we all agree.

Matt Hancock: Yes. In the event of a deal, I am content that the deal that is on the table that is 95% complete will be a good one for the engagement of the UK with the rest of the EU in the future, alongside our engagement with the rest of the world.

On the financial side, we have already put more money into science than we could possibly lose from the European scientific programmes, so we will have a record level of Government science funding next year no matter what happens in the deal with the EU, and that is a great thing.

I appreciate also that it is not just about the money; it is about the collaborations. I want those collaborations to be as rich and deep as possible. Of course, scientific collaborations are global as well, by their nature. I do not think anybody should try to reduce the level of collaboration because of the nature of the trade arrangements between



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two countries. That has not been the approach in the past and I think that our global leadership on health research will continue. I am determined to do everything I can to make that the case.

Q150 **Chair:** That is very helpful, but it is also about the workforce and the workforce being able to move here easily. Is that something about which you are going to be having discussions with your colleagues in the Home Office?

Matt Hancock: Yes. When I say we want to attract the brightest and the best, clearly researchers, and indeed their wider teams, are a critical part of that. We are incredibly proud of the UK's advanced position in medical research, and we are going to sustain it and keep improving on it every year.

Chair: Thank you for coming.